OSF

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To: Family Care Pilots

From: Monica Deignan, Family Care Project Manager

Subject: New Procedural Requirements for Operating under the Family Care Waivers

There will be some procedural changes in 2002 when Family Care Pilots begin operating under the new Family Care waivers. The pilots in Fond du Lac, LaCrosse, Portage and Richland counties began operating under the new waiver on January 1. The pilot in Milwaukee County will begin on April 1.

After those dates in Family Care CMO pilot counties:

1. The home and community-based services waivers administered by the Division of Supportive Living - CIP IA, CIP IB, CIP II, COP-W, CSLA and the Brain Injury Waiver - are no longer available to individuals in the Family Care target group. County agencies may not bill on the CARS lines for those waivers for anyone in the Family Care target group.
2. Pre-approval of care plans is no longer required. There is no longer a need to send care plans to The Management Group (TMG) or to a Bureau of Developmental Disability Services CIS worker.
3. To enroll in Family Care, new applicants must have a contact with an enrollment consultant.
   - There must be at least a telephone contact with the enrollment consultant. During that contact, an individual or her/his legal representative may decide on the extent of the consultation they receive. They may decline further consultation and request immediate enrollment.
   - During the first month, as enrollment consultants are learning how to effectively consult with potential enrollees, staff from the Resource Center may participate with the enrollment consultant in consultations, at the enrollment consultant's discretion. Also during the first month, enrollment consultation may occur following actual enrollment if necessary to avoid delaying services to a potential enrollee.
4. An enrollee who has resources available for cost sharing, shares costs on the portion of the CMO's capitation payment that is attributable to waiver services, not on the actual services s/he receives. The enrollee's cost sharing will not vary from month to month, and the CMO is not required to refund any cost sharing collected in excess of the cost of services the enrollee receives. (For more information, see the attached description of how cost sharing is calculated in Family Care.)

Questions regarding these procedures may be directed to Charles Jones, OSF/CDSD, 1 S. Pinckney, Suite 340, P.O. Box 1379, Madison, WI 53701-1379, (608) 266-0991, jonescm@dhfs.state.wi.us.

Calculating Cost Sharing in Family Care

1. CMS requires that cost sharing be applied only to 1915(c) waiver services.

2. For 2002, to be eligible to cost share (Group B), an enrollee can have a maximum special income limit of $1,635 per month. And, in calculating cost sharing liability, all enrollees first get a minimum "basic needs allowance" of $725 deducted from their income. Subtracting $725 from $1,635 results in a general limit to the amount of cost sharing any individual could ever pay of $910 per month.

   However because of exclusions from countable income and special deductions from cost sharing, the actual cost share for most people will be less than that. Exclusions from countable income include such costs as child support, health insurance premiums, medical and remedial expenses, guardianship fees and other court ordered expenses. A "personal maintenance allowance" is also deducted from the individual's cost sharing. The personal maintenance allowance includes the $725 basic needs allowance and other special deductions, including an earned income disregard for people who work and a special housing allowance for people with high housing costs. For 2002, the total personal maintenance allowance is limited to no more than $1,105 per month.

3. Wisconsin's other waivers require monthly tracking of each individual's waiver costs, and an individual's cost sharing liability is further limited by the actual cost of waiver services that an individual receives. If the cost sharing collected exceeds the actual cost of an individual's waiver services, the excess must be refunded.

4. In Family Care, however, cost share liability is not dependent on the costs of waiver services the individual actually receives. Instead, cost share liability is based on the average monthly cost of waiver services (calculated on a statewide basis) for the enrollee's target group.

5. For 2002, the average monthly cost of waiver-covered services is projected to be:

Projected Average Monthly Cost of Waiver Services for 2002

$1,022.63	Elderly
$1,149.99	Physically Disabled
$2,921.05	Developmentally Disabled

Methodology for Projecting Average Monthly Cost of Waiver Services for 2002

	2000 - Actual	2001 - Projected Inflation Factor - 5.41%	2002 - Projected Inflation Factor - 5.41%
Elderly	$918.00	$967.67	$1,022.63
Physically Disabled	$1,032.34	$1,088.18	$1,149.99
Developmentally Disabled	$2,622.19	$2,764.05	$2,921.05

6. Since each target group's average amount of waiver-covered services - the amount subject to cost sharing - exceeds the general monthly limit on cost sharing ($910), there is no need to further limit cost sharing based on a more limited liability for waiver services.

7. This means that:

   - Unless their available income and assets change, enrollees will have the same cost share each month (much like a premium) regardless of the amount of services rendered to them.

   - CMOs are not required to refund cost sharing that exceeds the actual cost of waiver services purchased or provided on behalf of an enrollee.